

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037397

FILED VS. NOV 12 1959

2 9979

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

UNRECORDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) St Louis			Length of stay in 1b	c. CITY OR TOWN St Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Incarnate Word Hosp			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2254 Nebraska		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle Last BEACH				4. DATE OF DEATH Month Oct Day 30 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-23-1903	9. AGE (last birthday) 56	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Groves Con. Co.		11. BIRTHPLACE (City and state or country) Oklahoma		12. CITIZEN OF WHAT COUNTRY U S A	
13a. FATHER'S NAME William Beach		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Mary Beach			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 493-10-0192		17. INFORMANT Address Mary Beach 2254 Nebraska			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism - bilateral						INTERVAL BETWEEN ONSET AND DEATH 1 hr	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Styphic Lesions of Stomach & Hemorrhage						40 hr	
DUE TO (c) Styphic Rins Disease - Generalized						3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 201x						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from Sept 16-59 to 10-29-59 and last saw ^{her} him alive on 10-29-59 Death occurred at 3:45 AM 10-30-59 m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Blain P. Curtis MD (Degree or title)				22b. ADDRESS 3218 Hypocrite St. St Louis Mo		22c. DATE SIGNED 10-30-59 (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Nov 2, 1959	23c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery		23d. LOCATION (City, town, or county) St Louis Co.		Mo	
24. FUNERAL DIRECTOR Thomas Kutis ADDRESS 2906 Gravois		25. DATE RECD. BY LOCAL REG. OCT 30 1959		26. REGISTRAR'S SIGNATURE Earl Smith M.D.			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Eleanor Province

Licensed Embalmer No. 3403

P. O. Address 2906 Gravo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.